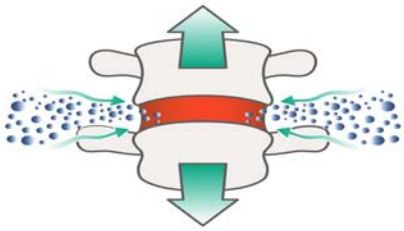

CROSS
SPINE & DISC
NON-SURGICAL SOLUTIONS

HEALTH CARE AUTHORIZATION FORM

PATIENT NAME:_____

PATIENT SS#:_____ DATE OF BIRTH:_____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **CROSS SPINE AND DISC** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

I give permission to CROSS SPINE AND DISC to use my address, phone numbers, emails and clinical records to contact me with appointment reminders, missed appointment notifications, birthday cards, holiday related cards, information about treatment alternatives, newsletters, emails, testimonials, or other health related information.

If CROSS SPINE AND DISC contacts me by telephone, I give them permission to leave a phone message on my home, cellular and work answering machine or voice mail and email addresses.

OPEN ROOM AUTHORIZATION

I give CROSS SPINE AND DISC permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations upon my request for such action.

I give CROSS SPINE AND DISC permission to treat me and or talk about my course of treatment in front of family members or personal friends that I personally bring into a treatment room during said course of treatment by clinic. By bringing said individuals along with me into a treatment room, it will be known that my protected health information regarding treatment can be discussed in front of said individuals, unless otherwise specifically indicated by patient to the doctor or provider of treatment. At that time, patient will request to speak to provider/doctor privately and or request that the individuals they brought into the treatment room should be removed.

By signing this form you are giving CROSS SPINE AND DISC permission to use and disclose your protected health information in accordance with the directives listed above.

EXPIRATION

The Authorization will not expire during patient's treatment and care at facility.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION in writing at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official at:
CROSS SPINE AND DISC, 7000 PEACHTREE DUNWOODY RD, BLDG 9-100, ATLANTA, GA 30328, PH 404-303-0266

The written notice must contain the following information: Your name, social security number and date of birth as well as a clear statement of your intent to revoke this AUTHORIZATION, the date of your request and your signature. The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by CROSS SPINE AND DISC for its own use/disclosure of PHI.

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, CROSS SPINE AND DISC will not refuse to provide treatment. *You have the right to inspect or copy the PHI to be used/disclosed.*

PATIENT NAME:_____PATIENT SIGNATURE:_____
DATE:_____

SIGNATURE OF GUARDIAN/PERSONAL REPRESENTATIVE:_____